

Tables

1	Recent changes in the Medicare program	1
1-1	Inpatient hospital services	7
1-2	Outpatient services	9
1-3	Skilled nursing services and outpatient rehabilitation services	9
1-4	Home health services	10
1-5	Physician services	11
1-6	Medicare+Choice	12
1-7	Other provisions directly affecting beneficiaries	13
1-8	Change in Medicare growth rates by provider sector: before and after the Balanced Budget Act	14
2	Medicare beneficiaries' access to quality health care	19
2-1	Selected characteristics of noninstitutionalized traditional Medicare and Medicare+Choice enrollees, 1998	24
2-2	Access to care for noninstitutionalized beneficiaries in traditional Medicare, by selected beneficiary characteristics, 1998	29
2-3	Satisfaction with care for noninstitutionalized beneficiaries in traditional Medicare, by selected beneficiary characteristics, 1998	31
2-4	Access to care for noninstitutionalized beneficiaries enrolled in Medicare+Choice, by selected beneficiary characteristics, 1998	33
2-5	Satisfaction with care for noninstitutionalized beneficiaries enrolled in Medicare+Choice, by selected beneficiary characteristics, 1998	35
2-6	Percentage of Medicare beneficiaries' income spent on health care, 1992–1996	38
2-7	Percentage of income spent on health care by low-income beneficiaries, 1992–1996	40
2-8	Out-of-pocket spending on health care by category for all beneficiaries, 1992–1996, adjusted for inflation	41
2-9	Distribution of 1995 and 1996 percentage of beneficiaries' income spent on health care, by level of 1994 percentage of income spent on health care	42
2-10	Out-of-pocket spending on care provided in long-term care institutions, 1992–1996, adjusted for inflation	42
2-11	Percentage of income spent on health care by beneficiaries with different coverage, 1992–1996	43
2-12	Out-of-pocket spending on health care by beneficiaries with different coverage, 1992–1996, adjusted for inflation	43
2-13	Income distribution of managed care enrollees and beneficiaries with Medigap who have access to managed care, 1996	44

2-14	Previous year supplemental insurance for beneficiaries in traditional Medicare and first-year Medicare+Choice enrollees who were in traditional Medicare, noninstitutionalized population	44
2-15	Percentage of aggregate expenditures on various budget items, 1996	45
3	Revising payment methods and monitoring quality of care in traditional Medicare	49
3-1	Home health users, average and median visits per user in 1994, 1997, and 1998	56
3-2	Dimensions, levels of severity, and items used for the home health case-mix system	58
3-3	RUG-III classification groups consistent with Medicare coverage criteria	60
3-4	Distribution of outpatient therapy users, payments, and average payments, by setting, 1996	62
3-5	Characteristics of selected patient assessment data sets	68
3-6	Change in total payments under combined payment for hospital operating and capital costs	72
3-7	Current policies and incremental case-mix refinement policy options	75
3-8	Cases in DRG 14, by APR-DRG and severity class, 1997	75
3-9	Average standardized cost for cases in DRG 14, by APR-DRG and severity class, 1997	76
3-10	Average absolute differences in standardized cost from group means, DRG 14 and refined DRGs, 1997	76
3-11	Aggregate average percent change in payments compared with current policies for three case-mix refinement options	77
3-12	Estimated distribution of hospitals by percent change in payments compared with current policies under each policy option, for selected hospital groups	80
3-13	Diagnosis related groups selected for expansion of transfer payment policy, 1999	82
3-14	Impact of expanded transfer policy on Medicare prospective payment system payments, by diagnosis related group, 1999	83
3-15	Percentage change in total payments due to recommended disproportionate share hospital policy changes, by threshold level and public/private teaching status	87
3-16	Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and urban/rural ownership	87
3-17	Average allowed charges for high-volume evaluation and management services, by level of visit, 1998	90
3-18	Change in evaluation and management service coding, by type of service, 1993–1998	92

4	Updating payment rates in traditional Medicare	97
4-1	Components of MedPAC's general framework for updating payments	101
4-2	Expenditure shares for selected physicians' services provided in ambulatory care settings, by setting, 1994–1998	108
4-3	Expenditure shares for high-volume physicians' services provided in inpatient and ambulatory care settings, 1994–1998	111
4-4	Simulated effects of an expanded sustainable growth rate system	113
5	Medicare+Choice: trends since the Balanced Budget Act	115
5-1	Medicare+Choice contract terminations and service area reductions	118
5-2	Beneficiaries with risk plans available, 1997–2000	118
5-3	Availability of plans with selected benefits, 1999–2000	120
6	Improving payment for end-stage renal disease services	127
6-1	Examples of separately billable laboratory tests and drugs	131
6-2	Calculating payments for patients with ESRD in Medicare+Choice	134
6-3	Medicare per capita monthly payment rate for ESRD demonstration enrollees in California, 2000	135
6-4	Productivity of dialysis facilities, by facility size, 1998	137
6-5	Trends in productivity for freestanding dialysis facilities, 1991–1998	138
6-6	Payment-to-cost ratios for composite rate payments for freestanding dialysis facilities, by dialysis modality and facility characteristics, 1991–1998	139
A	Impact of MedPAC's recommendations for reforming the hospital disproportionate share adjustment	149
A-1	Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and total margin quartile	151
A-2	Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and hospital location	152
A-3	Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and teaching status	152
A-4	Percentage change in total payments due to recommended disproportionate share policy changes, by threshold and proportion of Medicare and Medicaid patient shares	152
A-5	Selected payer cost shares by public/private teaching status	153
A-6	Proportion of total Medicare costs, by public/private teaching status	153

Figures

1	Recent changes in the Medicare program	1
1-1	1997 view of Medicare growth	4
1-2	Hospital Insurance Trust Fund: 1996 projections	5
1-3	Hospital Insurance Trust Fund: 1999 projections	14
1-4	Aggregate Medicare spending, fiscal years 1992–2010	15
3	Revising payment methods and monitoring quality of care in traditional Medicare	49
3-1	Percentage change in payments for option 1 and option 3, compared with current policies, by discharge volume, urban and rural hospitals	78
3-2	Distribution of hospital inpatient evaluation and management services for subsequent care, by HCFA Common Procedure Coding System code, 1993–1998	91
4	Updating payment rates in traditional Medicare	97
4-1	Distribution of codes for visits by new patients to physicians and outpatient departments, 1998	110
4-2	Distribution of codes for visits by established patients to physicians and outpatient departments, 1998	110
5	Medicare+Choice: trends since the Balanced Budget Act	115
5-1	Medicare+Choice (risk) plan enrollment	121